SPEC-D FORM (Optometrist/Ophthalmologist Certification)

MISSOURI DEPARTMENT OF TRANSPORTATION
MOTOR CARRIER SERVICES

CERTIFICATION BY LICENSED VISION PROFESSIONAL FOR SKILL PERFORMANCE EVALUATION (SPE) CERTIFICATE TO OPERATE INTRASTATE COMMERCIAL MOTOR VEHICLES

MAIL COMPLETED FORM TO:	ATTN: MEDICAL EXEMPTION PROGRAM MOTOR CARRIER SERVICES P.O. BOX 893 JEFFERSON CITY, MO 65102-0893	IF ASSISTANCE NEEDED, CALL: 573-522-9001 OR Toll Free at 1-866-831-6277 FAX 573-751-4354

SECTION 1. IDENTIFICATION OF DRIVER-APPLICANT (TO BE COMPLETED BY DRIVER APPLICANT.)

DRIVER-APPLICANT'S FULL NAME			MAIDEN/FORMER NAME(S)
RESIDENCE ADDRESS			GENDER (PLEASE CHECK ONE BOX) ☐ MALE ☐ FEMALE
CITY	STATE	ZIP	DATE OF BIRTH
(AREA CODE) HOME TELEPHONE # ( )	(AREA CODE) WORK PHONE # (IF ANY) ( )		SOCIAL SECURITY #

SECTION 2. IDENTIFICATION OF VISION PROFESSIONAL
(SECTIONS 2-7 TO BE COMPLETED BY OPHTHALMOLOGIST OR OPTOMETRIST.)

VISION PROFESSIONAL'S BUSINESS NAME			BOARD CERTIFIED ☐ YES ☐ NO
VISION PROFESSIONAL'S FULL NAME			BOARD ELIGIBLE ☐ YES ☐ NO
BUSINESS ADDRESS			
CITY	STATE	ZIP	
(AREA CODE) OFFICE TELEPHONE # ( )	(AREA CODE) OFFICE FAX # ( )		PROFESSIONAL CERTIFICATION #
FIELD OF SPECIALTY (PLEASE CHECK ONE BOX) ☐ OPHTHALMOLOGIST ☐ OPTOMETRIST			PROFESSIONAL LICENSE #
NAME OF CERTIFYING ORGANIZATION			
ADDRESS OF CERTIFYING ORGANIZATION			
CITY	STATE	ZIP	

SECTION 3. NATURE OF THE VISION DEFICIENCY AND DATE OF IMPAIRMENT

	DATE OF IMPAIRMENT:

NOTE: IF MORE SPACE IS NEEDED FOR YOUR RESPONSE(S) THAN THE FORM PROVIDES, PLEASE ATTACH ADDITIONAL SHEETS.

SECTION 4. VISUAL ACUITY

RIGHT EYE	CORRECTED:	LEFT EYE	CORRECTED:
	UNCORRECTED:		UNCORRECTED:

SECTION 5. TO BE COMPLETED BY OPTHALMOLOGIST IF APPLICANT HAS INSULIN-TREATED DIABETES MELLITUS (ITDM). (OPTOMETRIST IS NOT ACCEPTABLE IF APPLICANT HAS DIABETES.)

A YES ☐ NO ☐ — DOES THE APPLICANT HAVE ANY EVIDENCE OF DIABETIC RETINOPATHY (I.E., DISEASE OF BLOOD VESSELS IN THE RETINA)? EXPLAIN:

B YES ☐ NO ☐ — DOES THE APPLICANT HAVE ANY EVIDENCE OF DIABETIC RETINOPATHY, HE OR SHE MUST BE EXAMINED BY A **BOARD-CERTIFIED**, OR **BOARD-ELIGIBLE ENDOCRINOLOGIST.**
EXPLAIN:

C ☐ — FIELD OF VISION - PLEASE GIVE A BRIEF DESCRIPTION OF THE APPLICANT'S MEDICAL CONDITION FOR WHICH A SKILL PERFORMANCE EVALUATION CERTIFICATE IS NECESSARY.
←CHECK BOX TO CONFIRM COMPLETION.

D ☐ — IS THE PHYSICIAN FAMILIAR WITH THE APPLICANT'S MEDICAL HISTORY THROUGH ACTUAL TREATMENT?
←CHECK BOX TO CONFIRM COMPLETION.

☐ YES - HOW LONG? ☐ NO - EXPLAIN:

E ☐ — VISION PROFESSIONAL MUST ATTACH FORMAL PERIMETRY THAT IDENTIFIES THE FIELD OF VISION OF EACH EYE, INCLUDING CENTRAL AND PERIPHERAL FIELDS, TESTING TO AT LEAST 120° IN THE HORIZONTAL FOR EACH EYE, AS WELL AS AN INTERPRETATION OF THE RESULTS IN DEGREES OF FIELD OF VISION.
←CHECK BOX TO CONFIRM THAT THE COMPLETED FORMAL PERIMETRY AND INTERPRETATION REPORT IS ATTACHED.

SECTION 6. VISION PROFESSIONAL'S CERTIFICATION

A YES ☐ NO ☐ — I CERTIFY THAT, IN MY MEDICAL OPINION, THE APPLICANT'S VISUAL DEFICIENCY IS STABLE AND HAS SUFFICIENT VISION TO PERFORM THE DRIVING TASKS REQUIRED TO OPERATE A COMMERCIAL MOTOR VEHICLE, AND THAT THE APPLICANT'S CONDITION WILL NOT ADVERSELY AFFECT HIS/HER ABILITY TO OPERATE A COMMERCIAL MOTOR VEHICLE SAFELY.

NOTE: IF MORE SPACE IS NEEDED FOR YOUR RESPONSE(S) THAN THE FORM PROVIDES, PLEASE ATTACH ADDITIONAL SHEETS.

SECTION 7. DRIVER-APPLICANT'S CERTIFICATION AND VERIFICATION

I CERTIFY THAT, EXCEPT FOR THE PHYSICAL CONDITION(S) INDICATED ABOVE, I AM OTHERWISE FULLY QUALIFIED UNDER PART 391 ("QUALIFICATION OF DRIVERS") OF THE FEDERAL MOTOR CARRIER SAFETY REGULATIONS (TITLE 49, CODE OF FEDERAL REGULATIONS) TO DRIVE AND OPERATE COMMERCIAL MOTOR VEHICLES.

I CERTIFY THAT I HAVE DISCLOSED TO ALL MEDICAL PROFESSIONALS WHO ARE IDENTIFIED IN THIS FORM AND ALL ATTACHMENTS, THE FULL, TRUE AND CORRECT INFORMATION CONCERNING MY MEDICAL HISTORY AND MY PRESENT PHYSICAL CONDITION.

I EXPRESSLY AUTHORIZE THE MISSOURI DEPARTMENT OF TRANSPORTATION, THE MISSOURI HIGHWAYS AND TRANSPORTATION COMMISSION, AND THEIR AUTHORIZED PERSONNEL, TO FURTHER INVESTIGATE MY QUALIFICATIONS, AND I AUTHORIZE ALL PHYSICIANS, HOSPITALS, PHARMACIES, AND ALL OTHER HEALTH CARE PROVIDERS OR HEALTH INSURERS TO ALLOW ACCESS AND PROVIDE COPIES OF ALL OF MY PERSONAL MEDICAL RECORDS TO AUTHORIZED PERSONNEL OF THE MISSOURI DEPARTMENT OF TRANSPORTATION OR THE MISSOURI HIGHWAYS AND TRANSPORTATION COMMISSION FOR THESE PURPOSES.

I CERTIFY THAT IF ANY INFORMATION PROVIDED TO MODOT IN RELATION TO THIS APPLICATION, INCLUDING (BUT NOT LIMITED TO) MY ADDRESS, PHYSICAL CONDITION, DRIVING RECORD, LICENSE STATUS, OR ANY OTHER PERTINENT INFORMATION, SHALL CHANGE OR BECOME INCORRECT AFTER THIS DATE, THEN I WILL IMMEDIATELY FILE AMENDED OR SUPPLEMENTAL INFORMATION, SO THAT ALL RELEVANT INFORMATION PROVIDED TO MODOT IS KEPT CURRENT AND ACCURATE.

I UNDERSTAND THAT, IF A SPE CERTIFICATE IS ISSUED TO ME, THEREAFTER MODOT MAY SUSPEND AND REVOKE ANY SPE CERTIFICATE ISSUED TO ME IF I VIOLATE OR FAIL TO COMPLY WITH ANY APPLICABLE TRAFFIC LAWS, REGULATIONS OR ORDERS, OR ANY CONDITIONS STATED IN MY SPE CERTIFICATE, OR IF I AM INVOLVED IN ANY TRAFFIC ACCIDENT OR CRASH WHILE DRIVING ANY MOTOR VEHICLE.

I FURTHER DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF MISSOURI AND THE UNITED STATES OF AMERICA THAT ALL THE INFORMATION STATED IN THIS APPLICATION AND ALL ATTACHED INFORMATION ARE TRUE AND CORRECT.

APPLICANT'S SIGNATURE	DATE SIGNED:

APPLICANT'S NAME (Printed)

SECTION 8. VISION PROFESSIONAL'S VERIFICATION

I FURTHER DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF MISSOURI AND THE UNITED STATES OF AMERICA THAT ALL THE INFORMATION STATED IN THIS APPLICATION AND ALL ATTACHED INFORMATION ARE TRUE AND CORRECT.

VISION PROFESSIONAL'S NAME (Printed)

VISION PROFESSIONAL'S SIGNATURE	DATE SIGNED: